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ABSTRACT

The development and implementation of an adolescent suicide prevention program at the Fairfax County Public Schools in 1982 is described. The major components of the program are described: (1) background; (2) organizing and planning; (3) resources; (4) workshops; (5) activities for students; and (6) evaluation and review. Emergency visits to mental health facilities are an essential step in creating a community safety net. A copy of the guidelines for dealing with a suicide is included. Also included is a student stress program that, while circumventing direct discussion of suicide with students, focuses on many of the factors found to be prevalent in the populations at risk. Peer counseling is another forum in which issues related to suicide may arise; an excerpt of the peer counseling curriculum is included. Appended is a 63-item bibliography. (SI)

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EA 020 597

THE ADOLESCENT SUICIDE PREVENTION PROGRAM

FAIRFAX COUNTY PUBLIC SCHOOLS
Department of
Student Services and Special Education
Fairfax, Virginia
January 1985

Revised February 1987

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INTRODUCTION

Adolescent Suicide Prevention - A School And Community Concern

In 1982, the Fairfax County Public Schools began the development of a comprehensive adolescent suicide prevention program designed, in cooperation with other community agencies, to make students, teachers, and parents aware of the problem of adolescent suicide, some of its causes, and effective means of prevention. The program was first implemented during the 1982-83 school year.

This booklet describes the development and implementation of the adolescent suicide prevention program and some of the techniques and resources that contributed to its success. Readers who want additional information about the program may contact Beatrice Cameron, Assistant Superintendent for Student Services and Special Education, Fairfax County Public Schools, (703-691-2964), or Myra Herbert, Coordinator of School Social Work Services (703-691-2288), Fairfax County Public Schools, 10310 Layton Hall Drive, Fairfax, Virginia 22030.

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I THE ADOLESCENT SUICIDE PREVENTION PROGRAM

THE ADOLESCENT SUICIDE PREVENTION PROGRAM

A. RATIONALE

1. Background

Suicide is the second leading cause of death among persons age 15 to 19 in the United States. Even more alarming, the number of adolescent suicides has increased steadily during the past three decades, and affluent, middle-class communities have suffered a disproportionate number of such deaths. Public awareness and concern has grown as the number of children lost to suicide has increased, and citizens in communities throughout the country have looked to public agencies, including the public schools, for help.

Fairfax County, Virginia, a 400- square-mile governmental jurisdiction in the Washington D.C. metropolitan area with a population of over 668,000 is a well-educated and largely middle-class community with a median family income of $54,100, based on 1985 data. The county has a small but growing minority population, a large percentage of which is also middle-income. It is one of those communities that statistics suggest would experience the problem of adolescent suicide.

The Fairfax County Public Schools is the tenth largest local school district in the United States, serving over 125,000 students in 177 different schools during the 1985-86 school year. Forty eight of those schools are intermediate (grades 7 and 8), secondary (grades 7 through 12), or high schools (grades 9 through 12), a few of which have student bodies of over 4,000 students.

During the 1980-81 school year, there were 11 recorded adolescent suicides in Fairfax County. Another 9 deaths among youths took place during the summer or after graduation, or were not recorded as suicides because of the circumstances or the wishes of the families. These tragic events dramatically increased community concern and caused school officials to begin discussions during the 1981-82 school year with representatives of community mental health agencies about the development of an adolescent suicide prevention program and the proper role of the public schools.

In July, 1982, the Fairfax County School Board included in its instructional priorities for the 1982-83 school year a direction that the staff "work with community resources to address the mental health of troubled students." As a part of the activities undertaken to carry out this School Board priority, Superintendent William J. Burkholder asked the Department of Student Services and Special Education to be responsible for the development and implementation, in cooperation with other responsible community agencies, of a comprehensive program for the prevention of adolescent suicide, a program intended to help parents, teachers, and students understand the problem, its causes, and the means of prevention. The task required innovative planning and creative thinking because there seemed to be no model programs found anywhere in the United States from which to take guidance.

The process used to develop and implement the Fairfax County Public Schools' Adolescent Suicide Prevention Program and the major components of the program are described in the following pages. From the beginning, parent-teacher associations were asked to assure that parents would be actively involved in planning the program. We are convinced that parental involvement, always an important part of planning school programs, contributed significantly to the eventual success of this program. Suicide is a sensitive subject that many parents are reluctant to face and fearful of discussing with their children. Having parents participate fully in the planning process ensured that the final program would reflect parental concerns and at the same time helped establish parental support for and understanding of the specific prevention activities that comprised the program. The organizational support of the parent-teacher associations also provided an appropriate forum for explaining the details of the suicide prevention program to each local school community.

2. Research

A review of the available research proved a useful first step in assembling the information that would lead to a design for the program. There is valuable information in the psychiatric literature about treatment of the suicidal teenager and useful theory in sociological literature on the reasons young people take their lives. The study of this information was helpful in focusing thinking about the design of a program, especially for staff members without a mental health background.

The bibliography included at the end of this handbook contains some of the classic publications on suicide, some definitive clinical references that illustrate differing points of view, and several books written for laymen. At many stages in the planning and implementation process, both staff members and parents requested reading material. The literature search enabled us to provide appropriate and differentiated reading lists for staff members, for parents and for students.

We also conducted research to determine the availability of information about suicide deaths of adolescents in the community. When possible, it was worthwhile to review the school records and interview the teachers or other school personnel who remembered a student who had become the victim of suicide. We tried to go as far back as possible in the child's school career. In some instances, this process enabled us to piece together telling clues that indicated when and where the difficulty began. The information aided in building profiles to identify children who might be at risk. The staff quickly discovered that some of the stereotypes about adolescent suicide did not always hold true for students in Fairfax County.

Cooperation from the Police Department in obtaining information about previous suicides proved to be invaluable. Much of the information to which the police had access was public information, but obtaining it directly from the police eliminated the need to search out newspaper articles, which are frequencly inaccurate when dealing with cases of suicide. Knowing the means used by adolescents who committed suicide helped the personnel conducting the prevention program to have credibility with parents about the need to remove guns from homes or to dispose of potentially lethal medications. Accurate data on previous suicides also helped identify those times of the school year during which the staff should exercise more vigilance.

3. Assessement of Community Resources

A second preliminary step was the preparation of a list of all the mental health agencies and practitioners in the community, including both public agencies and professionals in private practice. The list was used to determine which community agencies and professionals should be asked to assist in the development and implementation of the suicide prevention program. The group finally selected was an appropriate mixture of public and private agencies and included representatives from community mental health centers; hospitals; universities; the medical association; the police department; the mental health association; parent-teacher associations; and psychiatrists, psychologists, and clinical social workers engaged in private practice.

All of the groups or individuals asked to participate in the program were aware of the problem of adolescent suicide, very concerned about it, and willing to commit their time and resources. The willingness of other agencies to participate in a joint effort, and the availability of their resources, contributed significantly to the success of the program.

B. ORGANIZING AND PLANNING

1. The Advisory Committee

Following the review of the available research and the assessment of community resources, an advisory committee was appointed to make recommendations for the design of the program and to identify the resources needed to implement it. The committee included members of the school staff with different responsibilities, representatives from the community agencies identified through the community resources assessment, professionals in private practice, and parents. The committee was composed of:

- Principals
- Staff from the central administration of the school system
- Medical professionals
- Social workers
- Psychologists
- School guidance counselors
- Police officers
- Parents
- Staff from the Department of Social Services
- School nurses

School staff members were appointed to the advisory committee by the Superintendent. Representatives from the other agencies and groups were obtained by sending a letter of invitation to the head of the agency explaining in detail the need for the prevention program, its aims, and the meeting schedule and task assigned to the advisory committee. We believe this step helped assure interagency dedication to the success of the advisory committee and contributed to the support given the suicide prevention program that the committee finally developed. We actually received more interest in service on the advisory committee than we were able to accommodate without making the committee too large to function. All these offers were retained, however, for possible use later in the implementation of the program.

2. Designing the Program

The primary difficulty faced by the advisory committee in recommending a specific program of in-school activities for the prevention of adolescent suicides was the urgent need to design effective activities that would not impinge too much on a school day already crowded with academic and extracurricular activities. Notwithstanding this problem, the committee was able to recommend a series of awareness and prevention activities designed to reach teachers, parents and students.

The advisory committee concluded that the first objective of the program should be to provide suicide awareness and prevention training to the faculties of the high and secondary schools because teachers in those schools were serving the most vulnerable group of students. The committee recommended that the training be provided through a two-step program to be conducted in each school.

The committee recommended that on the first day, the principal devote a regular faculty meeting to introducing the problem of adolescent suicide and to presenting prevention techniques. The faculty presentation, to be coordinated by designated members of the schools staff, might include a showing of a film, and a 20-minute follow-up session conducted by a mental health professional. As the program evolved, a concise lecture proved more effective because of the time constraints. The format for these sessions would usually be developed by the school's social worker and a psychologist and would include

distribution of selected written materials on adolescent suicide, including the pamphlet by Arthur S. Freese, Adolescent Suicide: Mental Health Challenge (Public Affairs Pamphlets, 381 Park Ave., South, New York, New York 10016) and About Suicide Among Young People (Channing L. Bete Co., Inc. 200 State Road, South Deerfield, Ma. 01373).

On the second day, the day following the faculty meeting, a team composed of the school's social worker, the school's psychologist, a guidance counselor, and a community mental health professional would be present in the school throughout the school day to talk with teachers in informal sessions during teacher planning periods. This offered opportunity for teachers to ask questions and discuss the information presented at the faculty meeting. The persons conducting these follow-up sessions in each school would be provided advanced training to ensure continuity from school to school. Where possible, they would also be persons who had direct, clinic experience with potentially suicidal adolescents.

The faculty training program recommended by the committee was begun in November, 1982. A copy of the Superintendent's memorandum to principals on this subject, dated November 18, 1982, is included at the end of Section D.

The follow-up sessions proved particularly useful because they permitted teachers to ask questions and discuss issues that they might have been reluctant to raise in a larger group. The sessions also permitted teachers to discuss individual children in confidence with a trained professional. Numerous children were referred to mental health personnel as a result of these follow-up sessions.

The advisory committee also recommended that presentations on adolescent suicide be held for parents throughout the school year, using school buildings, county libraries, and community centers. The programs for parents were to be scheduled for various times though the day and evening to attract the widest possible audience of parents working full-time, part-time, or in the home. These presentations, to be conducted jointly by a member of the school staff and a community mental health professional, might include the showing of an appropriate film and an open discussion led by a mental health professional.

All parent-teacher associations were notified that a suicide prevention program would be made available for any of their meetings. School principals were encouraged to urge local parent-teacher associations to sponsor such a program at a regular meeting. Organizations for single parents were also contacted and asked to sponsor a presentation for their members because national studies indicate that children from families affected by divorce may be vulnerable to an increased incidence of suicidal behavior.

The final part of the prevention program recommended by the advisory committee was a variety of information and prevention activities designed especially for students. The committee recommended that the subject of suicide be discussed with all students, either in separate workshops or in a designated class. The committee believed films could be used and good advantage could be made of the speakers trained in mental health, including school social workers and psychologists, staff members from the cooperating community agencies, and professionals in private practice. Talking with students about stressful issues and discussing suicide within that context has proved most successful.

The committee also recommended support for students who wanted to organize peer groups for discussion and counseling. Such support might include providing a person trained in mental health as a group leader, encouraging students to focus on recognizing friends in need of help, and dispelling the notion that it is somehow disloyal to discuss a friend's need with potentially helpful adults. The behavior profiles developed from the survey of the research and that data on recent suicidal deaths could also be helpful to students in recognizing danger signals.

Editors of student newspapers at high and secondary schools were encouraged to print interviews with community professionals on the subject of suicide. Students do read school newspapers, and our experience suggests that printed interviews on suicide help increase student awareness of the problem. A sample interview is included at the end of this section.

The advisory committee recognized the need to continue meeting throughout the school year to help in implementation of the activities it recommended and to evaluate their effectiveness. A copy of the committee's recommendations is included at the end of this section.

3. Implementing the Program

To implement the various suicide prevention activities recommended by the advisory committee, it was necessary to divide responsibility among the agencies and individuals who had agreed to participate. The school system was responsible for overall management of the program, for publicizing the program, for informing and training building principals and other staff members who would conduct the activities in each school, and for communicating with parent-teacher associations. The community mental health centers accepted responsibility for organizing and assigning the mental health professionals who would be the speakers or group leaders for the programs for teachers and parents. Having this task performed by a single agency ensured that all the qualified professionals who had volunteered would have an opportunity to participate and that the work load would be equitably divided.

The mental health association agreed to find space in the communities for the parent programs to be held in the daytime during working hours and to provide additional publicity for the suicide prevention programs that local parent-teacher associations and other community groups agreed to sponsor. The medical association representative helped recruit medical professionals in private practice as speakers and kept the advisory committee current about attempted suicides that appeared in hospital emergecy rooms while maintaining anonymity for the individuals involved. The police department provided anonymous profiles of the characteristics of children who had committed suicide and supplied current information about suicide attempts without breaching confidentiality. In addition, the police agreed to alert school personnel whenever a public school student committed suicide so that appropriate follow-up activities could be scheduled to help teachers and students deal with the aftermath. The police also worked with the school staff to develop a standard series of questions that could be included in the post-suicide interview usually conducted by the police with the family and friends. The content of the questions did not go beyond what police usually ask in such situations, but having agreement on what should be asked helped ensure that complete information was collected in each case.

RECOMMENDATIONS OF THE SCHOOL/COMMUNITY ADVISORY COMMITTEE ON ADOLESCENT SUICIDE PREVENTION

August 30, 1982

PRESENT:

Pamela Rubin, Social Worker, Quander Road Center, FCPS
Nancy Medis, Coordinator of Guidance Services, FCPS
Judith Byrne, Social Worker, Area II, FCPS
Deborah Feiner-Child, Social Worker, Adolescent Unit, Fairfax Hospital
Elaine Creigh, Visiting Teacher, Area II, FCPS
Joel Friedman, Psychologist, Woodburn Community Mental Health Center
Miriam Gilbert, Social Worker, Area III, FCPS
James McMurr, Child Psychiatrist, Fairfax Hospital
J. J. Whalen, Sgt., Fairfax County Police Department
Bonnie Lillie, Visiting Teacher, Area IV, FCPS
Arnold Small, Psychologist, Northern Virginia Mental Health Institute
Lee Jackson, Social Worker, FCPS
Elizabeth McManus, Director, Mental Health Association of Northern Virginia
Phyllis Carson, Social Worker, Area I, FCPS
Karen Dempster, Assistant Principal, Oakton High School, FCPS
Myra Herbert, Coordinator of Social Work Services, FCPS, Program Coordinator

The following are the recommendations made by the School/Community Advisory Committee on Adolescent Suicide Prevention.

Programs are to be presented to three groups in the school community; the faculties and administrators, the parents of students, and the students themselves.

I. Faculty and School Administration

A monthly faculty meeting will be scheduled in each high school at which the film, "Adolescent Suicide: A Matter of Life and Death" will be shown. This will be followed by a twenty-minute informational session conducted by a mental health speaker from the community. The following day, the school social worker, psychologist, and guidance counselor - and in some cases the community speaker - will hold a day-long open session in the home economics living room where the atmosphere is relaxed and coffee can be made available. School personnel will be invited to attend for informal discussion throughout the day.

The school social work service has developed a format that can be effectively used in this structure with a handout that should prove a ready reference. In addition, all faculty members will receive a copy of the National Institute of Mental Health publication entitled "Adolescent Suicide: Mental Health Challenge."

Many of the school social workers and psychologists have had direct clinical experience with suicidal adolescents. For those who have not, inservice programs will be held in each area. A three-hour inservice is scheduled for the guidance counselors on November 3, 1982.

II. Parents

Presentations will be held over the school year at county libraries, community centers, and in school buildings. Repeating similar presentations at various times of the day will ensure that all interested parents can attend at a time and location that is convenient to them. The sessions will be dually presented by a school representative and a community representative. They will take the form of showing a film and then having open discussion with the mental health professional present.

All parent/teacher associations will be notified by the school administrator or school social worker that such a school/community presentation is available for PTA meetings. It is hoped that school personnel will urge PTA groups to arrange such presentations.

Divorced parent organizations will be contacted and also urged to accept such programs for their meetings. National studies indicate that children from families affected by divorce are a vulnerable population.

III. Students

Community speakers will be offered to student assemblies at no cost. Much of the focus will be to dissolve some of the common adolescent fantasies about death.

Health education classes will be encouraged to show films and invite outside speakers. Again, the community agencies have volunteered time and knowledgeable personnel. The school social worker and psychologist will also be available to meet with such classes or help the teacher prepare a presentation. Such classes offer more informal discussion than the large assemblies. These two sessions might well be done in sequence as with faculty meetings.

A number of students have expressed interest in organizing peer groups for discussion and counseling. This is to be encouraged but a professional group leader provided. Here again, both school and community representatives will provide such service for three to five session groups. A target area for student programs is that of recognizing friends who need help and dispelling notions of the disloyalty of discussing this need with potentially helpful adults.

Student newspaper interviews of community mental health authorities on the subject of suicide are to be encouraged. Students do read their school newspapers, and two such interviews reported last year were effective. All community groups present have volunteered to grant such interviews to student reporters.

The Fairfax County Police Department will make available the anonymous social and situational suicide data to the School/Community Advisory Committee. This will be invaluable in targeting the at-risk population in Fairfax County.

The Mental Health Association has agreed to help build a network for scheduling speakers and locations, and all of the organizations involved will offer voluntary speakers and will recruit other organizations.

The School/Community Advisory Committee initially convened will meet periodically through the school year to plan implementation of the approved program and to evaluate the individual efforts as they are conducted.

Article from The W. T. Woodson High School
Student Newspaper, The Cavalcade

EXPERT SAYS STRESS, PRESSURE PLAGUE TEENAGERS

By Kathy Ledebur

Alarmed at the rise in teenage suicides, Fairfax County Public Schools had developed a program to inform teachers, parents and students about the problem of teenage suicide. The program's creator, Myra Herbert, the Coordinator of School Social Work Services, has testified before the Senate Committee on the Judiciary, Subcommittee of Juvenile Justice, and appeared on numerous television interviews to explain the program and its goals.

The Adolescent Suicide Prevention Program, developed in 1981, attempts to reach teachers, parents, and students. Each intermediate and high school in the county had an inservice dealing with depression and suicide in teenagers. PTA's started similar programs, and schools tried to inform and aid students. The segment of the program aimed at teachers attempted to make teachers aware, explain warning signs of suicide, and suggest where to refer the students for help.

Because many people feared that a program about suicide with students would encourage suicide, the program was reshaped to address causes of stress and depression in students. In this program students that were identified as having some type of problem shared their experiences and how they tried to cope. Hearing the problems of other people helped the participants realize that theirs are not unusual and are shared by many teenagers.

In "Addressing the Issue of Teenage Suicide in A Public School System", Herbert's report to the Senate committee, she outlines some stress-producing factors in adolescent life that could eventually lead to suicide. She explains that it is usually a combination of causes that lead to suicide.

If a friend confides that they are considering suicide, Herbert suggests that you take them seriously, offer to talk about it, and talk to an adult to get professional help. It is important to realize that although they may want you to keep it a secret you must go to someone for help.

The school psychologist, social worker, or guidance counselor may know where to get help. Ms. Herbert suggests that to ask for help if considering suicide, a student should start by saying that they really have a problem and need to talk to someone right away.

POLICE QUESTIONS

Were any of the following factors present?

1. Depression
2. Drug use on a regular basis
3. Original family not intact
4. Child adopted (if possible, age at adoption)
5. Child under psychiatric care
6. Counseling or therapy ever suggested
7. Relocated military family
8. Frequent family moves or a recent move
9. Both parents working
10. Pressure for achievement
11. Recent trauma

    Examples:
    - death of someone close
    - broken romance
    - home or school move
    - loss of a good friend
    - disappointment (failure to make a team, loss of election, bad grades, etc.)
12. Recent changes in behavior

    Examples:
    - social to isolated
    - active to lethargic
    - achieving to non-achieving, etc.

COMMENTS:

C. RESOURCES

1. Human

The suicide prevention activities recommended by the advisory committee created the need for a pool of trained mental health professionals to be available as speakers or group leaders for the faculty training sessions and the information programs for parents and to serve as resource persons for the prevention activities serving students directly. The pool was created by using school staff members with approprate training and experience, clinical practitioners on the staff of the cooperating mental health agencies, and professionals in private practice.

Many of the young professionals in private practice welcomed the opportunity to meet with teachers and parents on this subject. In the Commonwealth of Virginia behavioral science professionals as well as medical professionals are licensed, and there were many with the experience and training that qualified them to serve as speakers and group leaders. School staff members developed a checklist to ensure that all the necessary information was covered by each person who served as a speaker or conducted a workshop. A copy of the checklist is included at the end of this section.

Our experience in implementing the adolescent suicide prevention program strongly emphasizes the importance of having mental health professionals, preferably those who have actually treated or counseled suicidal children, conduct the teacher training sessions and the parent programs. When such personnel are not available in the local school, help must be sought from the central office staff, community mental health agencies, or professionals in private practice.

We found many fine educational specialists in the schools who worked adeptly with children and were sympathetic to their problems, but suicide is a mental health issue, and an effective prevention program must be based on leadership from experts in this field. Teachers and guidance counselors should not be expected to become psychotherapists but they can learn to be alert to symptomatology and knowledgeable about proper referral procedures. The issues of over-involvement and of crisis intervention have to be taken into account, and there are modes of behavior and symptomatology that are apt to be overlooked or misunderstood by the untrained.

Teachers can, of course, take up the general topic of suicide or use a related approach to discuss social and emotional issues with students in the classroom or in another forum. Many of our teachers did this skillfully and thereby contributed to the success of the suicide prevention program.

2. Audiovisual

Many of the schools and parent groups asked for recommendations about audiovisual materials that could be used as a part of their suicide prevention efforts. There is an abundance of materials available, but much of it is of poor quality or unsuitable for use in a program sponsored by the public schools. Some materials deal with the subject unrealistically; others are too euphemistic, too alarming, or inappropriate for middle-class students and parents.

A committee composed of members of the school staff, mental health professionals, and parents was appointed to review audiovisual materials and make recommendations. We were looking for different audiovisual materials to serve the several different audiences at which the program was directed. For the presentation to parents, the committee sought films and other materials that were direct but not so frightening as to cause rejection of the subject. More sophisticated and detailed materials were required for teachers, guidance personnel, and mental health professionals. The committee reviewed a variety of films, filmstrips, and other materials. A list of the films finally adopted for use in the program is included at the end of this section. In all cases, however, the committee emphasized that a film or other audiovisual material should only be used to supplement the presentation of a knowledgeable speaker.

3. Printed Information

The most attentive audience of teachers, parents, or students did not absorb all that was said in a presentation. For that reason, speakers were encouraged to prepare and hand out additional written information as a part of their programs. They were asked to include such things as the relevant points of their presentation, the signs and symptoms of depression or crisis in children, guidelines for receiving information and reacting to it, and directions about what to do in specific situations. Speakers were urged to be certain that their written materials were in a simple and straightforward style, not overly dramatic, and emphatic about the need to take warning signs seriously and to make them the basis for preventative actions. Samples of the written materials used by some of the speakers are included at the end of this section.

The following pamphlets have been provided by the school system for each teacher as part of the awareness session presented to all high school and intermediate school faculties.

Adolescent Suicide: Mental Health Challenge by Arthur S. Freese. (Public Affairs Pamphlets, 381 Park Avenue South, New York, New York 10016)

About Suicide Among Young People (Channing L. Bete Co., Inc., South Deerfield, Massachusetts 01373)

Suicide and How to Prevent It the American Association of Suicidology (Merck Sharp and Dohme, Division of Merck and Co., Inc., West Point, Pennsylvania 19486)

TEENAGE SUICIDE FILMS

Death and Dying: A Teenage Class

10 minutes, produced by CBS News and distributed by CRM/McGraw-Hill Films, 110 15th Street, Del Mar, CA 92014

Presents an innovative approach to high school education on the topics of death and dying and explores the range of attitudes teenagers have as they face (or avoid) the subject.

Childhood's End: A Look at Adolescent Suicide

28 minutes, produced by Kensington Communications and distributed by Filmakers Library, 113 East 58th Street, Suite 703A, New York, NY 10022

Surveys the life events and attitudes of adolescents involved in four different aspects of suicidal crisis: threatening, attempting, and actually committing suicide, as well as grieving for the loss of a friend whose death was due to suicide.

Teenage Suicide: The Crime Families Never Forget

60 minutes, Alan Landsburg Productions and distributed by Films, Incorporated, 733 Green Bay Road, Wilmette, IL 60091 (800-323-4222)

Narrated by Timothy Hutton (Ordinary People), this film explores the lives-and deaths-of four teenagers. This is a frank examination of a tragic subject.

Adolescent Suicide: A Matter of Life and Death

39 minutes, produced by Forum Ltd., and distributed by the American Personnel and Guidance Association, Film Order Dept., 5203 Leesburg Pike, Suite 400, Falls Church, VA (Skyline Towers) (703-820-4700)

Backed by the authoritative commentary of noted suicide expert Dr. Seymour Perlin of George Washington University, this film is designed to raise questions that will lead to increased discussion and greater understanding of the problem of teenage suicide. Appropriate for high school students and their instructors as well as mental health professionals, ministers and church groups, and law enforcement officials.

Too Sad to Live

60 minutes, Massachusetts Committee for Children and Youth, 14 Beacon Street, Suite 706, Boston, MA 02108

Four sensitive vignettes of troubled young people. Especially recommended for guidance counselors and mental health professionals.

Amy and the Angel

30 minutes, Learning Corporation of America, distributed by Simon and Schuster, 108 Wilmont Road, Deerfield, IL 60015 (800-621-2131)

Best for intermediate-age students.

Suicide: Causes and Preventions

35 minutes, Human Relations Media, 175 Tompkins Avenue, Pleasantville, NY 10570. Literate and thorough. Good for older high school students.

Cry for Help

Hospital and Community Psychiatry Service, Film Library/Visual Aids Service, University of Illinois, Champaign, IL 61820. Useful for parents and school personnel.

Suicide: Causes and Prevention

(2 filmstrips), Sunburst Communications, Room GN 2, 39 Washington Ave., Pleasantville, NY 10570. Useful for parents and school personnel.

Teenage Suicide

MIT Teleprograms, Inc., 3710 N. Commercial Ave., North Brook, IL 60002, 312-291-9400. Useful for school personnel.

Suicide Prevention and Crisis Intervention

(12 films, 6 tapes), Charles Press Publishing, Inc., P.O. Box 830, Bowie, MD 20715. Useful for mental health professional and counselors.

Suicides

(16mm and videocassette), Behavioral Sciences Media Laboratory, Neuropsychiatric Institute, UCLA, 760 Westwood Plaza, Los Angeles, CA 90024, 213-825-0448. Useful for mental health professionals and counselors.

Teens Who-Choose Life:

The Suicide Crisis Sunburst Communications. Pleasantville, N.Y. 10570. Good for intermediate age students and faculties.

Teen Suicide: Who, Why and How You Can Prevent It.

Guidance Associates, 90 South Bedford Rd., Mount Kisco, N.Y. 10549. Useful for High School Students.

Martin H. Sarnes, M.D.
Child and Adolescent Psychiatry

PROFILE OF THE SUICIDAL ADOLESCENT, 1981

Age: 15-19 years
Sex: Male • Female (females approaching parity)
Race: American Indian • Caucasian • Black
Ordinal Position: First Child

Family: Chaotic
a. Absence of parent, particularly the father
b. Recent separation, divorce, death
c. History of parental depression and/or suicide (attempted or actual)
d. Alcoholism
e. Frequent separations from adolescent (as child as well)
f. Overtly and/or covertly rejecting

Predisposing:
a. History of psychiatric illness, especially depression, in childhood
b. Prior suicidal attempts
c. Recently ruptured relationship
d. Drug/alcohol abuse
e. Physical illness
f. Late maturity in males
g. Menstruation

Symptomatology: Generally, a sudden and sustained change in behavior and relationships often dramatically different from the prior state.
a. Predominance of anger
b. Frequent complaints of "boredom"
c. Somatisation-headaches and belly aches predominate
d. Irritability
e. Sleep disturbances
f. Academics: decreased performance, truancy, cutting classes
g. Increased risk-taking behavior
h. Frequent/consistent acting-out behavior: promiscuity, vandalism, theft, etc.
i. "Hyperactivity"
j. Persistent feeling of being evil, rotten, bad
k. Sense of being a burden
l. Sense of hopelessness, being rejected (most often in nonverbal productions)
m. A well-worked-out-plan and time for the suicide act
n. Overt signs such as crying, sighing, etc., less predominant but may also see the withdrawn, apathetic, disinterested adolescent

Differential Diagnosis:
a. Organic brain syndrome-particularly as produced by drugs/alcohol
b. The beginning of a severe physical or psychiatric illness (schizophrenia)
c. LD/hyperkinesis

THE SUICIDAL YOUNGSTER: HOW YOU CAN HELP

The following are preventive steps for the mature adult dealing with the suicidal youngster:

Step 1 Listen
The first thing a person in a mental crisis needs is someone who will listen and really hear what he is saying. Every effort should be made to understand the feelings behind the words.

Step 2 Evaluate the seriousness of the youngster's thoughts and feelings. If the person has made clear self-destructive plans, the problem is apt to be more acute than when his thinking is less definite.

Step 3 Evaluate the intensity of severity of the emotional disturbance.

It is possible that the youngster may be extremely upset but not suicidal. If a person has been depressed and then becomes agitated and moves about restlessly, it is usually cause for alarm.

Step 4 Take every complaint and feeling the patient expresses seriously.

Do not dismiss or undervalue what the person is saying. In some instances, the person may express his difficulty in a low key, but beneath his seeming calm may be profoundly distressed feelings. All suicidal talk should be taken seriously.

Step 5 Do not be afraid to ask directly if the individual has entertained thoughts of suicide.

Suicide may be suggested but not openly mentioned in the crisis period. Experience shows that harm is rarely done by inquiring directly into such thoughts at an appropriate time. As a matter of fact, the individual frequently welcomes the query and is glad to have the opportunity to open up and bring it out.

Step 6 Do not be misled by the youngster's comments that he is past his emotional crisis.

Often the youth will feel initial relief after talking of suicide, but the same thinking will recur later. Follow-up is crucial to insure a good treatment effort.

Step 7 Be affirmative but supportive.

Strong, stable guideposts are essential in the life of a distressed individual. Provide emotional strength by giving the impression that you know what you are doing, and that everything possible will be done to prevent the young person from taking his life.

Step 8 Evaluate the resources available.

The individual may have both inner psychological resources, including various mechanisms for rationalization and intellectualization which can be strengthened and supported, and outer resources in the environment, such as ministers, relatives, and friends whom one can contact. If these are absent, the problem is much more serious. Continuing observation and support are vital.

Step 9 Act specifically.

Do something tangible; that is, give the youngster something definite to hang onto, such as arranging to see him later or subsequently contacting another person. Nothing is more frustrating to the person than to feel as though he has received nothing from the meeting.

Step 10 Do not avoid asking for assistance and consultation.

Call upon whomever is needed, depending upon the severity of the case. Do not try to handle everything alone. Convey an attitude of firmness and composure to the person so that he will feel something realistic and appropriate is being done to help him.

Additional preventive techniques for dealing with persons in a suicide crisis may require the following:

- Arrange for a receptive individual to stay with the youth during the acute crisis.
- Do not treat the youngster with horror or deny his thinking.
- Make the environment as safe and provocation-free as possible.
- Never challenge the individual in an attempt to shock him out of his ideas.
- Do not try to win arguments about suicide. They cannot be won.
- Offer and supply emotional support.
- Give reassurance that depressed feelings are temporary and will pass.
- Mention that if the choice is to die, the decision can never be reversed.
- Point out that, while life exists, there is always a chance for help and resolution of the problems, but that death is final.
- Focus upon survivors by reminding the youngster about the rights of others. He will leave a stigma on his siblings and other family members. He will predispose his friends and family to emotional problems or suicide.
- Call in family and friends to help establish a lifeline.
- Allow the youngster to ventilate his feelings.
- Do not leave the individual isolated or unobserved for any appreciable time if he is acutely distressed.

These procedures can help restore feelings of personal worth and dignity, which are equally as important to the young person as to the adult. In so doing, the adult helping agent can make the difference between life and death. A future potentially productive young citizen will survive.

ASSESSING SUICIDAL POTENTIAL IN YOUNG PEOPLE

Symptoms of depression are not always strikingly apparent, especially among youth. When these signs often do appear, the youngster may not have all the classical signs, such as loss of appetite and weight. It is a mistake to feel that an individual will not take his life unless he is clinically depressed. Adult depression and youthful depression may not be synonymous. Behavior patterns to look for in potentially self-destructive youth include the following:

- Adolescents contemplating suicide are apt to have little solid verbal communication with their parents. In fact, this is part of the problem. They are more likely to communicate with a peer or another interested individual in whom they have some faith and trust. Thus, if it is apparent that a youth cannot talk to his parents, the listener should be alert to the nuances of a serious problem.

- A prized possession may be given away with the comment that it will not be needed any longer.

- The individual is apt to be more morose and isolated than usual.

- Young males are likely to have experienced the loss of a father or a close male figure through death or divorce before the age of 16 years.

- Girls who attempt suicide are likely to show much difficulty with their mothers, especially in the presence of an inadequate father figure.

- Adolescents are apt to smoke heavily, suggesting the presence of severe tension or anxiety.

- General efficiency and school work performance may decline markedly.

- Drug and alcohol use have increased in recent times, accompanied by anxiety, depression, and irritability.

- Even though apparently "accidental," one should be alert to instances of prior self-poisoning behavior, if known. The same youngster who tries to kill himself frequently has a history of self-poisoning, often requiring medical treatment. Ultimately, this behavior will result in self-distruction.

- Homes in which the professional suspects child-abuse, or finds the so-called "battered child" syndrome, are cause for serious concern, since there is mounting clinical evidence to indicate that future violence, including suicide, may evolve from abuse in childhood. If the youngster feels openly rejected by his parents, this feeling should be noted, even if severe physical punishment is absent.

- It may be helpful to look for verbal or behavioral signs which suggest a desire to get even with parents. A prominent component in suicidal behavior is the wish to make those left behind sorry that they did not treat the victim better when he was alive.

Subtle verbal clues may take three forms: (1) talking about another individual's suicidal thoughts; (2) inquiring about the hereafter, usually referring to a third person; and (3) discussing legal matters like the disposal of personal property, or the handling of documents such as insurance policies or wills.

THE SUICIDAL YOUNGSTER: HOW YOU CAN HELP

Suicidal periods usually last for only a short period of time. The goals of crisis intervention with the suicidal youngster are to: (1) get the person through the suicidal crisis without their hurting themselves, (2) convey a sense of hope that their situation can improve, (3) increase their perception of alternative ways of dealing with the problem, (4) identify and mobilize resources that can help the person with their situation.

Step 1 Assess the suicidal risk factors utilizing all sources of information available to you

Do not be afraid to ask directly if the person has entertained thoughts of suicide. Experience shows that harm is rarely done by inquiring into such thoughts at an appropriate time. In fact, the suicidal individual often welcomes the query and the opportunity to open up and discuss it. Remember, the more detailed an individual's thoughts and plans, the more serious the suicidal possibility. However, all suicidal thoughts should be taken seriously.

Step 2 Listen

The most important thing for a person in distress is someone who will listen and really hear what he is saying. Be empathetic and interested.

Step 3 Evaluate the seriousness of the youngster's thoughts and feelings

It is possible for a youngster to be extremely upset but not suicidal or to appear mildly upset and yet be suicidal. Try to understand where the person is at in all areas of his/her life and the meaning attached to these.

Step 4 Take every complaint and feeling the person expresses seriously

Do not dismiss or discount the person's concerns. Let the person know that you understand their perspective but that you may also be able to see things in another way.

Step 5 Begin to broaden the person's perspective of their past and present situation

Point out that depression often causes people to see only some things (the negatives) and to be temporarily unable to see other things (the positives). Elicit positive aspects of the person's past and present which are being ignored but which could be regained.

Step 6 Be positive in your outlook of the future

Hook the person on the idea that perhaps you know something that they don't. The youngster's predictions of a hopeless future are only guesses, not facts. Contrast the finality of death with the uncertainty which the future holds. Spectulate how the person's life would be different if just one or two changes could be made.

Step 7 Help the person to increase his perception of alternatives to suicide

Look at what the youngster hopes to accomplish by suicide and generate alternative ways of reaching the same goals. Suicidal persons have often prematurely ruled out perfectly viable options or have generated only one or two solutions to a problem before giving up hope.

Step 8 Act specifically

Help the person begin to make some concrete plans, in small steps, that will begin to resolve the problem. Give the youngster something definite to hang on to. Just setting up the next meeting time with you, in itself, is a helpful concrete step.

Step 9 Evaluate available resources

Help the person to identify and mobilize resources that can lend support during the crisis. Suicidal persons often withdraw from available support just when they need it most. Let the person know that you will help in any way that you can and that others can help also. Strong, stable supports are essential in the life of a distressed individual.

Step 10 Do not hesitate asking for assistance or making a referral

Call upon whomever is needed depending upon the severity of the situation. Do not try to handle everything alone. Convey an attitude of firmness and self-assurance so that the person will feel that you know what you are doing and that whatever is necessary and appropriate will be done to help the young person and prevent him from taking his life.

Additional preventive techniques for dealing with the person in a suicidal crisis may include:

- Build trust. Don't lie or make false reassurances.
- Don't buy instant recoveries or reassurances that the crisis is over after only one session. Some individuals who are acutely suicidal will do this to test your level of interest and concern.
- If you believe the youngster is acutely suicidal and is refusing voluntary help, you may have to consider notifying a relative or guardian and perhaps even initiating an involuntary commitment procedure.
- Avoid philosophical discussions about suicide and the "right-to-die"—they can't be won. Rather point out that there is nothing to be lost by trying to resolve the situation with your help and the help of others since suicide is an option that will still be available later. But, if the choice is made to die, that decision can never be reversed.
- Give reassurance that depressed feelings are temporary and will pass with time. Note that suicide is a permanent solution to a temporary problem and that while life exists, there is always a chance for help and resolution of the problem.
- Never challenge a suicidal individual to commit the act in an attempt to shock him out of it—the person is likely to accept the challenge.
- Try to elicit from the individual possible deterrents to committing suicide. For example: how it would affect parents and other survivors, or failing in the attempt and winding up paralyzed or brain-damaged for life.
- Arrange for a receptive individual to stay with the youth during the acute crisis. Do not leave the youth isolated or unobserved for any appreciable length of time if he is acutely distressed.

These procedures can help restore feelings of personal worth and a sense of hopefulness for the future. If the youngster can be convinced that his cry for help has been accurately heard and that he need not feel alone at times of crisis, then an episode of suicidal crisis can be successfully resolved and the youngster will be strenghtened for meeting the adaptive challenges he or she will face in the future.

SCHEDULE FOR ASSESSMENT OF SELF-DESTRUCTIVE POTENTIALITY

I. Intrapersonal aspects

A. Intention
   1. Conscious intention
      a. Awareness of the effect of his threats and/or attempts on others
      b. Awareness by the person of the results of his own self-destructive behavior
      c. Patient's knowledge about the method contemplated or used
      d. Conscious provisions for rescue (has made or is making)
   2. Unconscious intention
      a. Constellation of dynamics (important in self-destruction): anxiety, tension, guilt, depression, hostility, and dependency
      b. Kinds of fantasies: death, rescue, hurting, killing self or others, failure, impotence, loss of hope
      c. Unconscious manipulation of others through threats or attempts
      d. Life pattern of person: dangerous activities or occupations
      e. Unconscious provisions for rescue (had made or is making)

A. Ego organization
   1. Impulsivity versus efficacy of controls
   2. Rigidity versus flexibility
   3. Isolation versus relatedness

II. Interpersonal aspects

A. Communicative aspects
   1. Degree of directness of the communication (is it specific and its implication unavoidable, or is it a tenuous communication?)
   2. What is being communicated? Desperation, at end of rope, anger, desire for help, irritation, disdain
   3. To whom is the communication addressed? To specific persons or to world at large; if to specific persons, what kind, are they living or dead?
   4. Purpose of the communication: to cause guilt, prepare others for death, manipulate them

B. Environmental aspects: who are the significant others in the environment?
   1. Patient's attitude toward environmental and/or significant others, facilitating or inhibiting positive communication
   2. Attude of significant others toward the patient, facilitating or inhibiting positive communication
   3. Cultural and religious attitudes toward death

III. Implementation (in attempts)

A. Objective scale of lethality: (a) gunshot wound and explosives; (b) jumping from high places; (c) cutting and piercing of vital organs; (d) hanging; (e) drowning; (f) poisoning; (g) cutting and piercing of nonvital organs; (h) drowning (can swim); (i) gas poisoning; (j) analgesic and soporific substances
   1. Point of no return: length of time between initiation of act and occurrence of death
   2. Feasibility of intervention or rescue for interruption or reversal of self-destructive action

Compiled by Myra Herbert
Coordinator, School Social Work Services
Fairfax County Public Schools

SUICIDE CONFERENCE MATERIAL

I. Deal with your own feelings

- Considering death in youth is tragic and hard to understand
- First reaction is often shock
- Second is to argue and minimize
- Student should be heard and taken seriously

II. High risk children

- Students with clinical diagnosis of affective disorder
- Those with a history of impulsive behavior
- Loners
- Those who lack social skills
- Over-achievers
- Learning-disabled and under-achievers
- Depressed
- Pressured
- New Students
- Adopted children where there has been inadequate family bonding
- Latch key children
- Children with a history of suicide attempts

Important to note that these factors are often combined with one or more of the following. There is rarely a single factor that makes a student suicidal

- Poor parent/child relationships
- Absent parents – those traveling, divorced, ill
- Divorced parents in conflict
- Internal family conflict, either between parents or between siblings
- Conflict in combined families (those who have remarried and brought children into the new home)
- Financial Problems
- Personal pathology
  - Obsessions
  - Fantasies
  - Unreal fears
  - Little impulse control
  - Lack of personal boundaries
- Family pathology
  - One or both alcoholic parents
  - Suicidal parents
  - Abusive parents
  - Mentally ill parent or parents
- Cultural changes – generational conflict
- Belonging to a minority group
- High degree of family mobility
- Pregnancy

III. Symptoms

Personal drug and alcohol use may be present but is usually symptomatic and not casual. Problems usually begin long before drug use starts. Substance abuse may be a form of self-medicating.

- Personality or affective changes
  - Achieving to not achieving
  - Depression
  - Depression that disappears and is replaced by a sense of calm with no change in essential circumstances.
  - A sudden religious interest focusing on the afterlife
  - Giving things away or saying goodbye in some way
  - Discussion of death, dying, the hereafter
  - A sudden recklessness, perhaps an intense interest in dangerous sports
  - Isolation and detachment
  - Suicidal gestures (even unexplained automobile accidents)
  - Bizarre fads—autoerotic hangings, for example
  - Unusual accident proneness
  - A lack of aspiration
  - A sense of futility
  - Loss of appetite
  - Problems sleeping
  - Somatic complaints
  - Eating disorders—anorexia, bulimia

IV. Typical reasons

- Loss
  - Death of someone close, particularly a parent or family member
  - Suicide of someone close, particularly a parent or a family member
  - A broken romance
  - Departure of a close friend
  - A family move
- Loneliness
- Sense of frustration
- Anger
- Lack of a future
- Unmet parental expectations
- Physical illness
- Mental illness
- Feeling unloved
- Poor self-image
- Major disappointment
  - Failure to make a sports team
  - Failure in a class
  - Bad grades
  - Social rejection
- Not being accepted by college of choice

V. Times of danger

Rites of passage
- Graduation
- Completion of parental divorce

Anniversaries of unhappy events (parental deaths, severe losses, etc.)
Holidays, particularly family holidays
Vacation times, especially if child is isolated
Change of season
Custody disagreements

VI. Helpful responses

LISTEN

- Discuss fantasies, talking realistically often dispels them; child may think there will be a reunion with a loved one; may think it is punishment for family or friends; think somehow he/she will witness the result; often have magical belief that death is reversible.
- Don't argue
- Don't lecture
- Ask if there is a definite plan (plans denote an especially high risk)
- Suggest child talk to parents or other helpful adults, give names of persons in school who are prepared to help, get in touch with parents or other resources yourself.
- When planning to talk with parents, tell child and ask if he or she wishes to be present
- Make a plan with student; don't leave arrangements open-ended; set up a time to meet again
- Tell student friends
- Do not leave a student at risk alone
- Suggest professional help; set it up and accompany child if necessary
- Do not attempt to be a psychotherapist
- If in contact with parents, suggest they get rid of guns, medications, poisons in the home
- Display interest, care, and concern. Attempt to get a commitment to communicate with you about steps taken toward help. Emphasize that there are other solutions.
- If there is a sense that the child is at risk, pull out all the stops. It is better to chance over-reacting than not to pay enough attention.

1. Level I: School Administrators

We conducted a workshop for all school administrators, particularly principals, assistant principals, and pupil services administrators, before the suicide prevention sessions for the school faculties were held. Many administrators needed information on the subject of suicide and all had to be informed about what was being planned for individual schools. The success of the suicide prevention activities in a school rested on the involvement of the principal. Faculties often took their cues from the leadership; when principals took an active part in suicide prevention activities, so did more of the faculty members.

We sought an outside speaker of considerable reputation in the community for the administrators workshop. We wanted a mental health professional who could talk from direct experience with young people and offer some guidelines for solutions. Fortunately, we were able to obtain Dr. James Egan, Chief of Psychiatry at Children's Hospital National Medical Center. He discussed the statistics in the nation and stressed the seriousness of the problem.Dr Egan's presentation served as the keynote address to all the suicide prevention activities and set a high standard for all the programs that followed.

2. Level II: School Coordinators

Following the workshop for administrators, each high and secondary school was asked to appoint a staff member to be the school's suicide prevention coordinator. The coordinator became responsible for:

- setting up the faculty training session with an appropriate speaker
- arranging suitable written material to be handed out in coordination with the speaker and the central office staff
- functioning as the resource person to the parent-teacher association and to student organizations
- setting up or reinforcing channels for referrals to community resources
- maintaining a well-developed list of public and private resources

A special workshop was arranged for the suicide prevention coordinators to ensure that the faculty training sessions in each school would be organized and presented in the same way and include all the necessary information.

Workshops were also provided to those staff members in the local school who worked directly with children in counseling roles: school social workers, psychologists, and guidance counselors. They became responsible for coordinating the referral of individual cases to community mental health agencies after the program was implemented. The number of referrals sharply increased as a result of the suicide prevention program, and good interagency communication became essential if urgent situations were to be given immediate attention by the appropriate agency. The school system policy on school personnel responsibility and emergency procedures to be followed are clarified including taking students to mental health facilities. Later, a committee was appointed to work toward further improvements in interagency communication. The development of good working relationships between the several participating agencies was an important component of the success of the suicide prevention program.

3. Level III: Teacher Training

The suicide prevention training sessions for the teachers in each high and secondary school began in the fall of 1982. The structure of these sessions is explained in the Superintendent's memorandum to principals dated November 18, 1982, a copy of which is included at the end of this section. We were convinced that providing training to teachers in the high and secondary schools had to be the first priority in an effective program of suicide prevention.

Principals were urged to stress the importance of the subject and to make it the only one addressed at the faculty meeting. An informed faculty must be the first priority. Teachers could not be expected to deal easily with students on the topic of suicide without adequate preparation. The faculty meeting at which the subject was presented set the tone for all the other activities that took place in the school.

4. Programs for Parents

The parent-teacher associations and other community groups that agreed to sponsor programs on adolescent suicide for parents were encouraged to hold their programs about the same time that in-school activities for teachers and students were scheduled so that families who wished to discuss the topic further would be equally well-informed. School personnel were supportive and helpful to groups organizing parent programs, especially in the selection of appropriate speakers.

Attendance of teachers and school administrators at the programs sponsored for parents helped reinforce the importance of the subject and provided an opportunity for parents to ask questions about the in-school programs for teachers and students. In some instances, members of the advisory committee served as speakers for the parent programs. This proved useful to the committee in its evaluation of the effectiveness of the program and as one basis for planning for the future.

Unfortunately, some parents remained resistant to the subject of suicide, finding it too distressing to comprehend. They did not readily agree to cooperate in presenting the subject to other parents nor, in some cases, were they very enthusiastic about having their children exposed to the topic. Efforts to reach this group have been continued.

FAIRFAX COUNTY
PUBLIC SCHOOLS

The Administrative Center
10700 Page Avenue
Fairfax, Virginia 22030

MEMORANDUM

TO: High and Secondary School Principals

FROM: William J. Burkholder, Division Superintendent

SUBJECT: Adolescent Depression and Suicide Prevention

The Department of Student Services and Special Education has developed the following activities for your use in addressing the problem of adolescent depression and suicide prevention. The activities have been planned to reach faculty members, parents, and students themselves. I urge you to take advantage of these opportunities to meet the needs of your student body, staff, and community.

1. Inservice Presentations for Administrators and Teachers

The area coordinators of student services will be in contact with you to schedule a faculty meeting devoted to techniques for the prevention of adolescent suicide. This has been completed in two schools as of November 1, 1982. The film, Adolescent Suicide: A Matter of Life and Death, will be used, followed by a 20-minute information session conducted by a mental health professional.

The following day, the school social worker, the psychologist, a guidance counselor, and, when possible, a community mental health professional will hold a day-long open session in the home economics living room of the school, to provide a relaxed atmosphere with coffee available. Members of the faculty will be invited to attend these informal sessions during their planning periods throughout the school day.

The school social workers have developed a format for the sessions and have selected effective written material for distribution. The written materials are designed to provide faculty members ready reference information on the problem and will include a copy of the National Institute of Mental Health publication entitled "Adolescent Suicide: Mental Health Challenge," a Public Affairs Pamphlet.

Many of the school social workers and psychologists who will be conducting these sessions have had direct, clinical contact with suicidal adolescents. In addition, inservice training sessions will be provided in advance for all school personnel involved in conducting suicide prevention sessions, including the special three-hour inservice for all guidance counselors held on November 3, 1982.

If you have any questions or need assistance with these sessions, contact the area Coordinator of Student Services or Myra Herbert (691-2288), Coordinator of School Social Work Services.

2. Presentations for Parents

Throughout the school year, presentations for parents will be held at county libraries, community centers, and in school buildings. These presentations will be repeated to ensure that all interested parents will be able to attend at a time and location that is convenient to them. The presentations will be planned and scheduled by a cooperative effort of school personnel and community representatives. A film will be used with an open discussion to follow.

The PTA pyramid coordinators will be contacted and encouraged to inform local PTAs that similar presentations are available for PTA meetings and to urge PTAs to include suicide prevention among their topics for this school year. I hope you will support this effort and ask your PTA to schedule this topic. If you need additional information, call Myra Herbert (691-2288).

Organizations of single parents will be contacted and urged to take advantage of these presentations for their meetings because national studies indicate that children from familes affected by divorce are particularly vulnerable.

3. Presentations for Students

Schools are encouraged to arrange community speakers for student assemblies. These programs should focus on removal of some of the common adolescent fantasies about death.

Health education classes in each school are encouraged to make use of available films and to invite speakers. Community mental health agencies have agreed to provide qualified speakers. The school social worker and school psychologist will also be available to meet with health education classes and to help the teacher prepare for the presentation. These classes offer an opportunity for more informal discussion of concerns than will be possible in the assembly presentations. Health education class presentations may be scheduled at the same time as the faculty awareness sessions to increase school-wide awareness of the problem.

Contact Dr. Joel Friedman, Woodburn Mental Health Center, at 573-0523 for assistance with speakers for the student assemblies and health education classes. Dr. Friedman is cooperating with the Northern Virginia Mental Health Association in this effort.

Students have expressed interest in organizing peer groups for discussion and counseling. If you wish to encourage these groups, a professional leader can be provided through the use of both school and community mental health professionals. Peer discussion groups can emphasize techniques for recognizing friends that need help, and in dispelling notions that it is disloyal to discuss such needs with potentially helpful adults.

Interviews with community mental health professionals are available for student newspapers. Students read school newspapers, and two interviews printed last year in school newspapers were effective in increasing awareness.

Call Myra Herbert (691-2288) for assistance in organizing student peer groups and interviews for student newspapers.

FAIRFAX COUNTY
PUBLIC SCHOOLS

The Administrative Center
10700 Page Avenue
Fairfax, Virginia 22030

October 24, 1986

MEMORANDUM

TO: High School Principals

FROM: Robert R. Spillane

SUBJECT: Awareness Programs on Adolescent Suicide Prevention

Over the past three years, the Fairfax County Public Schools conducted an adolescent suicide prevention program which received nationwide acclaim. In order to ensure continuation of these efforts, I ask that you devote one faculty meeting during the 1985-86 school year to review with your staff information on adolescent suicide prevention. The social worker or visiting teacher who serves your school will coordinate the presentation and act as a resource person for PTAs and other parent organizations which may wish to sponsor similar presentations.

A second activity on adolescent suicide prevention that has proven to be successful in a number of high schools is the adolescent stress program where a panel of students discuss social and emotional issues of concern to them. During the discussion, students are encouraged to share successful coping mechanisms. This program is described in the Fairfax County Public Schools booklet, *Adolescent Suicide Prevention Program*, which is attached for your information. Schools are encouraged to initiate an adolescent stress program and should contact Myra Herbert, coordinator of school social work services, at 691-2288 for additional information about this program.

In addition to hosting a faculty presentation on adolescent suicide prevention and developing an adolescent stress program, another important aspect of the adolescent suicide prevention program is to assure that staff who serve adolescent populations—social workers, psychologists, and guidance personnel—remain in close contact with local community mental health centers. These staff members are aware of the emergency referral procedures that should be utilized and that they should periodically review these procedures. I ask that you review these procedures as well.

I thank you for your continued support of the Fairfax County Public Schools awareness programs on adolescent suicide prevention. For further information on any of these topics, please contact Myra Herbert.

FAIRFAX COUNTY
PUBLIC SCHOOLS

The Administrative Center
10700 Page Avenue
Fairfax, Virginia 22030

December 10, 1982

Ms. Pat Dotter
9832 Natick Road
Burke, Virginia 22015

Dear Ms. Dotter:

I am writing to inform you about the efforts being undertaken by the Fairfax County Public Schools to address the problem of adolescent depression and suicide prevention and to ask for your help in making this program a success.

The adolescent depression and suicide prevention program developed by the Department of Student Services and Special Education seeks to reach teachers, parents, and students. A faculty meeting will be held in each high school on this subject. On the day following the meeting, small group sessions will be provided for teachers to obtain further information and discuss concerns. Students will be provided workshops that focus on relationships, feelings, and methods of coping with problems and stress.

We very much want to involve parent groups in the community in this effort, and we hope to be able to make presentations for PTA groups in the high schools. We hope that you will encourage all the high school PTA groups in your pyramid to include this topic at one of their meetings this year.

An excellent program can be provided by using a film that we have available and arranging for a speaker from the school system or from a community mental heath agency. The film is entitled "Adolescent Suicide: A Matter of Life and Death." Once a PTA group has established a date, the film may be reserved by calling Mrs. Willi Kipp at 536-2600. Should the film be already scheduled for the date you want, please call Myra Herbert at the number given below and she will make arrangements to obtain another copy for you. Speakers may be scheduled by calling the following persons at your community mental health center.

Woodburn Center	Joel Friedman	573-0523
Northwest Center	Kenneth Disselkoen	471-6030
Mt. Vernon Center	Abby Sternberg	360-6910

We are also prepared to make this kind of program available to parents who cannot attend an evening meeting. If you would like to arrange a daytime meeting for your pyramid, please call Karen Scudder of the Mental Health Associaton of Northern Virginia at 536-4100. She will arrange a location and help in scheduling a speaker.

We hope you will encourage your PTA groups to take advantage of these opportunities for information on this vital subject. If you need any additional information or if we can be of assistance in any way, please call Myra Herbert, Coordinator of Social Work Services at 691-2288.

Sincerely,

William J. Burkholder
Division Superintendent

cc: Tony McMahon, President, Fairfax County Council of PTAs
Area Superintendents

CHECKLIST FOR SUICIDE PREVENTION WORKSHOPS

Please request the following of your speaker:

Discuss reaction to the subject of suicide and particularly in young people.

Explain why lecturing and minimizing is not helpful when talking with a troubled student.

Describe the kinds of children who are most at risk.

Give the signs and symptoms of suicide, particularly those school staff are in a position to observe, such as affective changes, achievement declines, discussions of death, or depressive writing or artwork.

Stress the inadvisability of over-involvement and indicate that the teacher's role is to assist in the identification of children at risk and refer the situation to the appropriate personnel.

Emphasize the necessity of parental involvement.

Please do yourself:

Discuss with your principal the measures used for referring children to school personnel and to outside agencies when necessary.

Make certain the school has adequate up-to-date list of community resources.

Ask that appropriate school personnel, social workers, psychologists, guidance counselors, be introduced at the meeting.

Stress to the principal that his or her involvement is essential to the success of the program.

Request that other school business be postponed unitil another meeting or be kept very brief.

Be certain that any handout material from the speaker is adequately reproduced and available, and that you have obtained the proper number of booklets for teacher distribution from the central office.

If your speakers require audiovisual equipment, make certain to make the necessary arrangements.

E. ACTIVITIES FOR STUDENTS

1. General

All the activities designed to increase student awareness were conducted after the faculty training session had been completed in the school, and, when possible, took place about the same time as the programs for parents in the community.

There were great differences of opinion about exactly what activities should be conducted for students. Consequently, no uniform model was developed for every school. Some individual schools developed very creative approaches and others were unable to implement any activities. Some schools took advantage of ideas developed by the students themselves. Each school needed to plan activities that worked within its own daily schedule and took into consideration the special needs and characteristics of its student body.

A number of schools reported the major obstacle to suicide prevention activities with students was the continuing inability of many adults to discuss the subject of death with students. As a result, we began the development of activities for students that looked at the larger problem of student stress. These activities, which are described in more detail later under the heading "The Student Stress Program," were an attempt to deal in a comfortable and natural manner with the social and emotional issues facing adolescents in a particular school, keeping in mind that each of the schools and student bodies were different. In these activities, many of the issues that are related to suicide emerged, but the participants dealt with them in a more easily way under the rubric of student stress and the hesitation of the adults, both parents and school staff, was greatly diminished.

2. Four Student Programs

These are brief descriptions of four student programs developed and implemented by the staffs in four different high schools.

First Program — The school's psychologist, social worker and guidance director trained a group of volunteer teachers in suicide awareness, formats for discussing the subjects of depression, stress, and problem solving. The teachers then went into classrooms on an established schedule and worked directly with students. At one school, this model was carried out by a group of physical education teachers using English classes to ensure that the prevention effort reached all students.

Second Program — A number of mental health professionals from the community were invited to speak to individual classes in the school. These sessions were conducted on the same day each week for four weeks and each speaker conducted three or four presentations to different classes during each day. Enough speakers were used to ensure that no one speaker was burdened and a large percentage of the student body heard a presentation.

Third Program — Students who were enrolled in the peer counseling elective course in the school (see Section IV below) worked directly with other students after being given thorough training. A group of volunteer teachers were also trained to support the work of the students, and community mental health professionals were invited to be speakers to individual classes.

Fourth Program — A staff psychologist, using a cognitive therapy model, prepared a workshop entitled "Dealing with Feelings of Hopelessness," based on the premise that thoughts cause feelings and there is a way to correct the process. She presented the workshop to the class of any teacher who requested it.

FAIRFAX COUNTY
PUBLIC SCHOOLS

Department of Student Services and Special Education
Belle Willard Administrative Center
10310 Layton Hall Drive
Fairfax, Virginia 22030

AGENDA

SCHOOL/COMMUNITY ADOLESCENT SUICIDE PREVENTION COMMITTEE

September 14, 1983

I. 1983-84 Prevention Program in the Intermediate Schools

- A. Implementation of Program
- B. Superintendent's Memo
- C. Improving Communication with PTA Groups

II. Four Prevention Programs Created by High School Personnel During 1982-83 School Year

A. Madison High School	Sandy Roeder
B. Langley High School	Ann Hargrove
C. Fairfax and Robinson High Schools	Mary Shaunessy
D. Herndon High School	Joan Houghton Charles Rembold

III. Discussion of Models to Use Over Entire School System

PROGRAMS WITH STUDENTS

While all 23 schools in the county did programs for faculty, these programs were done for students.

Annandale

In the days following the faculty inservice, 20 Annandale teachers did in-class discussion groups with students. This was at the suggestion of the principal.

Herndon

There were group discussions with counselors from the Northwest Community Mental Health Center which reached between 30 and 60 students.

Herndon has an ongoing peer counseling program that channels students having difficulty to the appropriate help.

There is also an excellent student-support program directed by a guidance counselor and an associate from NIMH. There are about five teachers also invoved.

Langley

An active member of the parent group put the school in contact with a social worker from Maryland who came to the school four consecutive Thursdays for four periods. She conducted between 20 and 25 classes and the estimate is that she reached between 500 and 600 students.

In addition, teachers who were interested and felt equipped conducted classroom discussion groups on stress. This was done in all psychology classes, some English, and some social studies classes.

Madison

The school psychologist, social worker, and guidance counselors put together an excellent program that dealt with both substance abuse and suicide. They trained a group of teachers, primarily from the PE department who then conducted awareness classes, usually in the English periods. These sessions continued over a three-day period, the final day being devoted to information about suicide and where to go for help.

McLean

There was some group counseling for students felt to be at-risk (drug users, low-achievers) or those who felt the need to participate. These were held on a weekly basis and reached between 50 and 75 students.

Oakton

Counselors from both Northwest Community Mental Health Center and Woodburn were available for walk-in clinics at the schools for a period of about seven weeks. This reached about 20 students. The guidance director, the school psychologist, and the visiting teacher conducted group sessions with about 14 students known to be at-risk.

One or two of the other schools had some voluntary sessions on stress or death and dying, but these do not seem to have been well-attended.

Madison Model

The school psychologist, social worker and guidance director train a group of volunteer teachers who then go into classrooms and talk directly with students. Training consists of awareness and a format for discussing the subjects of depression, stress, and problem-solving. At Madison, this was done with a group of PE teachers who set up programs in English classes. Consult Sandy Roeder, Madison High School.

Langley Model

Mental health professionals from the community are invited into the classrooms on a selected convenient day for four weeks — for instance, every Thursday for four weeks. The specialists remain for four hours and conduct about 25 classes over the total period. At Langley, this was done in all psychology classes, some English classes, and some social studies classes. Consult Ann Hargrove, Langley High School.

Herndon Model

Create a peer counseling program giving students adequate training to participate. Training classes are credit classes. Create a volunteer faculty group offering support to students in emergencies. Invite community mental health professionals into classrooms to discuss relevant topics with students. Consult Charles Rembold, Herndon High School (Lake Braddock after October).

Fairfax/Robinson Model

A psychologist using a cognitive therapy model presented a workshop called "Dealing with Feelings of Hopelessness" which began with the recognition that thoughts cause feelings and there is a way to correct the process. The workshop was given at the invitation of the classroom teacher and such invitations were made voluntarily. Consult Mary Shaughnessy and Collette Convisser, Area IV Office.

West Springfield has an active and effective peer counseling program and personnel is available for consultation. Consult Bonnie Lillie, Area IV Office.

JAMES MADISON HIGH SCHOOL

HOW YOU CAN HELP . . .

1. LISTEN

   The most important thing is to really pay attention to what your friend is saying. Try to understand what he or she is communicating and feeling.

2. TAKE YOUR FRIEND'S FEELINGS SERIOUSLY

   Respond seriously to what your friend is saying. Joking around, switching the subject, or trying to cheer your friend up may be ways of avoiding the problem. It will be more helpful if you respond to your friend's distress directly.

3. GO GET ADVICE

   Don't handle the problem alone. There are parents and many trained professionals who can enable your friend to get help.

By listening, by communicating your concern to your friend, and by getting advice, you will be directly dealing with the problem. This may give your friend something to hang on to as well as make you feel better.

WHERE TO GO FOR HELP . . .

At school, contact your:
1. Teacher
2. Guidance counselor
3. Members of Suicide Awareness Team:
   Mrs. Roeder
   Mr. Foehlinger
   Mrs. Kravitz

Offices are in Guidance Department

In community/home, contact your:
1. Parent or your friend's parent
2. Minister and/or rabbi
3. Physician

In crisis, call:

Northern Virginia Hotline	527-4077
Alexandria Hotline	548-3810
Woodburn Center	573-0523
Northwest Center	471-6030

MADISON HIGH SCHOOL EXAMPLE

The weekend warriors are downstairs in the basement-turned-into-a-rec room. Susan is there, on a fluffy rug, next to the potted palm tree, sitting cross-legged with a beer. Up until the beer, she had been drinking New York ice teas and her head is spinning. The stereo is playing--Marvin Gaye-- something about sexual healing, very loud. Out in the center of the room, a handful of people are dancing. Paul is out there. Susan came to the party with him. This is their last night as steadies. Paul is dancing with another girl, Pam, and though Susan isn't supposed to mind that, she does. She also minds that someone in the bathroom is getting sick. Seems someone at these parties is always getting sick. It's part of being young. Susan feels there's a lot of wasted energy in being young, and she's tired of it. Maybe another beer. Then she remembers the one she has. It's cold and heavy because it's full and fresh from Jerry's fridge. She takes a sip.

To be fair to Susan on their last night of going steady, Paul didn't want to go out--not to this party anyway. He wanted to sit at Susan's home and watch TV with her mom. But ever since the divorce, Mom's been acting real distant. To sit there with her would have been like sitting at a funeral. Susan wanted to get out, so she talked Paul into coming here, to Jerry's. Once Paul got here and got a beer down, the macho man of Watson High took over and ever since, Paul's been dancing and playing to the hilt the role of Joe Jock, throwing his muscles around on the dance floor. Maybe he's doing it to make her jealous. Susan can't tell. Paul keeps eyes closed when he dances and this reminds Susan of her father. Why doesn't Dad just die, she wonders. It would settle things for Mom. It's killing Mom to have Dad away from the house, alive. She worries. All Mom does when she comes home from work is call her friend on the phone or cry. Parents--they're as screwed up as the kids.

People at the party keep touching Paul. This more than his dancing with Pam annoys Susan. Even the other guys, as if for luck. They slap Paul on the back and slide their hands over his shoulder, followed by "Good seeing ya, Paul," and "How goes it my man?" How is she to keep people from touching him? He is big, and she would look a fool if she went over and tried to hold on.

A guy Susan knew two years ago comes and sits on the floor beside her. "Tee," he says, calling her by the letter she held up on the Watson High freshman cheerleading squad. She gave cheerleading up when she became a sophomore, preferring instead to spend time after school with this group. But the nickname "Tee" stuck and follows her around and into the second semester of her junior year. "How have you been?" he asks as if picking up a conversation begun two years ago. "How you doing in McKinley's college chem class?"

"I flunked the last two quizzes," she says, matter-of-factly. "If I'm lucky, I'll scrape through with a D."

"Thats bad. It must be pretty rugged stuff." He says this in reference to Susan's being an honors student in science. Susan resents him bringing up the past like this. To change the subject, she asks back, "How are things with you?"

"Oh, up and down. I thought you really liked that chem stuff."

"I used to," she says. "I don't know. I've been really tired lately. Tough times with Paul and with my folks. McKinley asked me to stop by his office Monday before class. He thinks I'm cracking." But her friend is not listening. His eyes wander around the room.

"Don't you dance, Tee?"

"No." Paul has stopped dancing with Pam. They have gone over to the bar.

"I guess the people who want to dance are dancing. Except me, anyway."

"I should have such problems," says Susan. "Dance with Pam. She's free." He gets up and goes over and waits along the wall to make his move. Susan is proud of herself for this little maneuver. It deserves another beer. She heaves herself up, but she rises too quickly and stumbles against the potted palm tree. She feels like a fool and senses Paul is looking at her. But Paul is in the middle of chugging down a beer. Everyone watches him. When he finishes, the weekend warriors cheer. Paul turns not to Susan, who is stumbling, but to Pam. They get close and exchange a kiss. Susan sees the kiss and decides to abandon Paul at the party. She has the car. She decides to drive around for a while. Ahead, the road bends suddenly, the tires scream out. Everything closes in and she panics. "I'll show you," she says over and over while she turns the wheel. The car slips off the road and into a tree.

F. EVALUATION AND REVIEW

1. Evaluating the Program

The advisory committee informally evaluated the effectiveness of the various activities and the program itself as the implementation was taking place. The program was an unprecedented effort for a large public school system and active monitoring greatly increased the chances for success and provided the information needed to make improvements. The evaluation process also helped maintain a sense of continued involvement for the cooperating community agencies. The committee concluded that the program was most effective where a model presentation or activeity was prepared in advance and then implemented in a local school as opposed to allowing each school's efforts to be totally self-designed. No independent evaluation has been conducted.

2. Revising and Expanding the Program

During the 1982-83 school year, the suicide prevention program was conducted in all high and secondary schools. The experience gained during the first year provided the basis for modifying or eliminating those activities which proved unsuccessful for whatever reason. Listening to the experience of the local school staff about why a particular activity did not work helped prevent similar mistakes when planning other activities.

During the 1983-84 school year, the program was extended to include all intermediate schools, which in Fairfax County serve students in grades 7 and 8. In the 1984-85 school year the program's emphasis was placed on expanding the number and kind of activities that work directly with students. That emphasis continued in the 1985-86 school year, but the awareness sessions were again held for high school faculties. In the 1986-87 school year the sessions were renewed for the intermediate schools and a new component was added for the elementary schools. Many of these had requested service in the previous year because of a variety of problems they were observing with elementary age children. An inservice was held for school mental health staff on school Depression and Self-Destructive Behavior in Elementary Children, and social workers and psychologists were asked to conduct workshops for faculties in the individual schools. The Public Affairs Pamphlet, Help for Your Troubled Child by Alicerose Barman and Lisa Cohen was distributed to the teaching and guidance staff to assist them in communicating with parents about behavioral difficulties.

Because of changes in both the staff and student bodies of our intermediate, high, and secondary shools, we anticipated that it would be necessary to repeat the major activities of the program at least once every three years and this has been the pattern.

MEMORANDUM

FAIRFAX COUNTY PUBLIC SCHOOLS Fairfax, Virginia 22030

September 16, 1983

TO: Mrs. Beatrice Cameron
Assistant Superintendent
Student Services and Special Education

VIA: Dr. James R. Annicchiarico, Director
Diagnostic and Placement Services

FROM: Mrs. Myra Herbert, Coordinator
School Social Work Services

RE: School/Community Adolescent Suicide Prevention Committee Meeting of September 14, 1983

I. The committee reviewed last years findings.

A. There were five documented suicides in the last school year. There had been eleven the year before.

B. All high schools did programs for faculty awareness, but very few with notable exceptions did anything directly with the students except in crisis situations. (See attached 1.)

II. The committee discussed the need for more programs at the intermediate level and felt that a memorandum from the Superintendent such as that sent last year to the high schools was imperative. In reviewing the wording of last year's memo, however, it is clear that there was much more emphasis put on the faculty portion and that student involvement was left to the discretion of the individual schools.

Everyone understands the hesitancy to make suicide the topic of classroom discussion with adolescents but there are other ways to approach the same material. Discussing feelings, troublesome life situations, ways of solving problems, and resources for seeking help will essentially accomplish the same goals.

III. There were four presentations made by school personnel who had developed good prevention programs directly with students over the last school year. (See attached II.)

IV. All four programs presented had advantages. It was the consensus of the committee representatives from the school system that the success or failure of any program lies with the principal and many still do not recognize that there is a serious problem that needs attention. Jim McMurr reported that there had been six suicide attempts, all Fairfax County students, in the Emergency Room of Fairfax Hospital in the past two weeks. All six had taken over-the-counter drugs such as aspirin and Tylenol.

V. The full committee recommends that a strong presentation emphasizing the scope of the problem and including the possible models to be given at one of the monthly secondary principals' meetings. (Murriel Price is the chairman and is extremely supportive. It is his feeling, however, that there is so much incidental business at those meetings that the subject would not get the attention it deserves. He feels that the Superintendent should call an extraordinary meeting much like the one for substance abuse.)

VI. Fully reconizing the staff problems, the committee suggests that there be a crisis resource counselor appointed in ever school. Annandale has accomplished this with existing staff by diminishing the regular load of one of the guidance counselors. Students know there is always an available person in the building.

VII. The committee also recommends that a task force be convened to work on the operational aspects of implementing student awareness and discussion programs, and that several high school principals be appointed as members.

VIII. There was wide support for peer counseling programs, which derive maximum benefit from minimum staff involvement. It was recognized that such programs need supervision and structure. One suggestion was that a consultation team be formed of those persons who have been involved in the formation of such programs.

Given the possible pitfalls, there are distinct advantages to such a program. Friendly, helpful peers dissolve the problems of lonliness, isolation, and alienation to a much greater degree than a staff of counselors can. They offer a support system in situations where students may have no other. It is a personal view that such a program can also teach care, compassion, and social concern in a world where these things seem diminished.

/bl
Attachments

NOVEMBER 3, 1986

LAKE BRADDOCK SECONDARY SCHOOL

RECITAL HALL

8:00 a.m. - 3:30 p.m.

DEPRESSION AND SELF-DESTRUCTIVE BEHAVIOR IN ELEMENTARY SHOOL CHILDREN

8:00 - 8:30	COFFEE
8:30 - 10:15	Symptoms of Depression and Suicidal Ideation in Young Children Gary Spivak, M.D., Child Psychiatrist, Private Practice and Georgetown University Medical School
10:15 - 10:30	BREAK
10:30 - 12:00	Working with Resistent Parents Sharon Schaefer, LCSW, Private practice and Faculty at Children's Hospital, National Medical Center
12:00 - 1:00	LUNCH
1:00 - 2:15	Survey of Current Research: Suicide in Latency Age Children Issac Wood, M.D., Child Psychiatrist, Virginia Treatment Center
2:15 - 2:30	BREAK
2:30 - 3:00	Research Treatment Implications Mimi Koller, M.D., Child Psychiatrist, Virginia Treatment Center Assistant Professor of Psychiatry, Medical College of Virginia

II. EMERGENCY VISITS TO MENTAL HEALTH FACILITIES

II. EMERGENCY VISITS TO MENTAL HEALTH FACILITIES

The community Mental Health Centers are the primary mental health support facilities for the schools. All schools fall into a designated catchment area and schools are encouraged to have active liaison with their centers. Fairfax County has three main centers and two branch offices.

When schools staff believes a student to be at risk for suicide parents are called immediately, asked to come to take charge of the student, and given the recommendation for mental health intervention. Parents are usually given three names from the school's referral list. One will be the local community mental health center; the others are apt to be agencies or private practitioners known to the school and regarded as responsible.

If parents cannot be reached or will not come to school for the student, he or she may be taken by school personnel to a community mental health emergency facility, or a hospital emergency room when there ia a psychiatric consultant.

Initially there were questions on the part of the both school staff and mental health staff about parental permission requirements and issues of payment. Clarifying memoranda were generated from the respective agencies and circulated to all personnel.

Schools were informed that they could take children they believed to be at risk to mental health facilities and those facilities were informed they could accept such visits and treat under those circumstances without parental permission or agreement for payment.

This was an essential step in creating a community safety net.

FAIRFAX COUNTY
PUBLIC SCHOOLS

Department of Student Services and Special Education
Belle Willard Administrative Center
10310 Layton Hall Drive
Fairfax, Virginia 22030

December 18, 1985

MEMORANDUM

TO: Area Coordinators of Student Services
Directors of Guidance

FROM: Beatrice Cameron Assistant Superintendent

SUBJECT: Emergency Visits to Mental Health Facilities

In situations where school personnel believe that a student is at imminent risk, is expressing suicidal thoughts, or has made a suicidal gesture, parents should be called immediately.

If the parents are not available, do not come to school to get the child, or cannot come to school but give their permission for staff to act on their behalf, it is accepted school policy for school personnel to take the child to a hospital emergency room, where there is a psychiatric consultant, or to a community mental health center for an emergency appointment.

The principal of the school should be notified immediately when a student is at risk. Two staff members should take the child to the emergency room or mental health center if the parent cannot or will not assist.

If you have any questions, please contact the coordinator of student services at your area office or Myra Herbert, coordinator, school social work services, at 691-2288.

/vt

MEMORANDUM

TO: Myra Herbert, Coordinator, Social Work Services
Fairfax County Public Schools

FROM: Shirley Costello, LCSW, Director
Mt. Vernon Center for Community Mental Health

John DeFee, PhD., Director
Woodburn Center for Community Mental Health

Barbara Maniha, LCSW, Director
Northwest Center for Community Mental Health

DATE: January 15, 1987

RE: Rights of Minors, Access to Services.

This memo is to clarify questions that have been raised concerning the rights of children seeking treatment without parental approval. It is the position of the mental health centers, in compliance with Virginia Code 554-325.2 (D), (3) and (4) (1982), that a minor seeking mental health services in the case of outpatient treatment for mental illness or emotional disturbance shall, with the minors consent, be treated without their parents' or guardian's consent. However, recognizing the importance of parental involvement in the treatment of the child, every effort shall be made to involve the family. In some situations clinical staffing decisions can be made, if it is believed that continued treatment would be counter-productive or inappropriate, to discontinue treatment of the child without parental involvement. When a child seeks treatment without parental approval, a clinical record is required which involves an administrative interview and the establishing of a fee for service. The initial fee will be based on the child's income. No one is denied service based on an inability to pay.

If questions or problems develop, please feel free to contact the appropriate community mental health center.

III. GUIDELINES FOR DEALING WITH THE EFFECTS OF A SUICIDE

III. GUIDELINES FOR DEALING WITH THE EFFECTS OF A SUICIDE

One result of implementing the suicide prevention program was that many schools asked for guidelines for dealing with a suicide by a student in the school. When a student commits suicide, it can have profound effects on the student body and the faculty of the school. Guidelines were developed and distributed to schools. A copy of the guidelines is included at the end of this section.

The initial reaction is one of profound shock and a concrete plan with role designations is essential. The days following an actual suicide are also a time when it is possible to reach personnel and parents who have been unwilling to face the problem before.

The more quickly follow-up activities are conducted in the school the less time students have to dwell on the event. Because of the adolescent tendency to respond emotionally to the loss of a classmate, it is wise to have a carefully designed plan of action that diffuses the excitement as rapidly as possible, although the sensitivity to grief is also important.

It is also most important to inform the schools in which there may be siblings of the deceased student.

FAIRFAX COUNTY
PUBLIC SCHOOLS

Department of Student Services and Special Education
Belle Willard Administrative Center
10310 Layton Hall Drive
Fairfax, Virginia 22030

MEMORANDUM

TO: Area Coordinators of Student Services

FROM: Beatrice Cameron, Assistant Superintendent
Student Services and Special Education

DATE: February 22, 1983

SUBJECT: Suggested procedures for School when a Suicide Occurs

The following guidance is offered to assist school administrators to implement appropriate activities:

1. Organize a staff counselor. There are many people who will be involved. Make sure everyone knows who is in charge of the school's plan.

2. Make a general announcement inviting friends of the deceased to meet in a group at a selected site. This works better than suggesting that counselors are on hand to talk with any individuals who wish to discuss the death. Kids are more apt to take part with peer support than they are on their own.

   Some schools have arrangements with the community mental health centers. If mental health counselors from the community are called in, they should work in conjunction with the people in counseling roles in the school.

   It has proved effective to allow such a student group to construct a memorial or plan a suitable commemoration of some kind. In one school, this took the form of donating blood to the Red Cross. In others, the students have written poems or prose statements to be read at the funeral. In one case where money was donated, an academic award was planned in the student's name. That kind of effort seems to mitigate against emotional escalation, and the feelings of helplessness.

3. Meetings with the immediate teachers or teachers from current years have proved useful. They have their own feelings to deal with and know that they are going to have to discuss the issue with the classmates.

4. The next day, a reconnoiter with the counselors is absolutely necessary. All manner of the unexpected will have occurred.

5. A full faculty meeting within the two-day period is essential. The faculty, whether they knew the child or not, will be very anxious. They need reinforced guidelines about what to discuss and how to discuss it and, in most cases, they are hearing suicide talk out of students who have never mentioned a problem before.

   We also found that that is a forum for dispelling inaccurate information and for reiterating the need for a calm, serious, undramatic treatment of the sitation.

6. This process will automatically identify other children at risk.

/dt

FAIRFAX COUNTY
PUBLIC SCHOOLS

Department of Student Services and Special Education
Belle Willard Administrative Center
10310 Layton Hall Drive
Fairfax, Virginia 22030

SUGGESTED PROCEDURES FOR SCHOOLS WHEN A SUICIDE OR SIMILAR CRISIS OCCURS

Revised February 19, 1986

The guidelines below are to assist school personnel in implementing appropriate activities for dealing with suicides or similar crises. It is important, however, to retain a measure of flexibility in all urgent situations, as events differ slightly and may require individual decisions. The following are presented as suggestions.

PREPLANNING

1. Decide in advance who is to be in charge during a crisis. Designate a substitute in the event that the appointed person is unavailable at the time of the emergency. Make certain that all staff know who those persons are.

2. Hold a thorough inservice on suicide prevention in every high school and intermediate school at least every other year, as promoted by the County Adolescent Suicide Prevention Program, using material and resources provided by that program. Offer the staff a brief reminder of procedures and resources in the years when full faculty meetings on suicide prevention are not scheduled. For new and transferred staff, hold a workshop during their orientation to the school.

3. Hold an inservice for the school secretaries on how to handle telephone calls and requests for information from the community. On a contingency basis, additional secretarial help is sometimes essential in times of emergency.

4. Use phone trees so that word can be communicated as rapidly as possible to persons who need the information and need to be involved.

5. Have a plan in mind for making space available for necessary meetings. Finding places for impromptu sessions in crowded schools can be a large problem, especially since availability of space varies with the time of day. Be aware that in some cases it will be necessary to go where the groups are rather than establish a location for a meeting.

CRISIS ACTIVITY

1. Notify the key people within the school system of the crisis. Contact the Area Superintendent immediately. The Superintendent's office will notify the appropriate School Board members and County Supervisors.

   Locate the social worker, visiting teacher, and psychologist and ask them to be present. They, along with the guidance directors, have received specialized workshops and they should be involved.

Since the local press often descends upon a school immediately after a tragedy, refer reporters to the Office of Community Relations (691-2909) for information. School staff may ask reporters and media representatives to leave school property.

Contact the Department of Student Services and Special Education. They have on-going police liaison that is helpful in ensuring that information is accurate and they will also offer supplementary assistance. Since first-hand experience and observation of crisis management helps SSSE in school system planning that is an integral part of a support network and of prevention, Myra Herbert, Cordinator of Social Work Services, asks to be called at 691-2288.

2. Do not wait to be begin activity. Delay can give rise to rumors that add another dimension to the existing problem. Delays also can promote anger on the part of the students at the school, a feeling that "no one really cares."

3. Prepare a general announcement to be given by the principal or designee. It is not necessary to mention suicide/death/accident or to give details. Information at the early stages is often inaccurate. A straightforward sympathetic announcement of a loss with a simple statement of condolence is recommended. If indicated, also a statement that more information will be forthcoming when information is verified, can be reassuring to the students.

   Be as truthful as possible when students ask direct questions. Truth tends to dispel speculations that quickly begin as soon as the news is out. Situations, however, in which the truth will not be known for some time, or in which the family does not want facts given, have to be dealt with individually.

4. Plan to hold a faculty meeting as soon as possible and even if it has to wait until the end of the day, give notice of the meeting early. Call guidance staff together and prepare them as a body for dispensing and providing general support to the teaching staff. Prepare brief written announcements to the teachers if those are possible to prepare rapidly. It ca be beneficial to request a professional from outside the school to conduct the faculty meeting or the faculty inservice simply because the immediate staff may be very personally caught up in the events. The central office or the area office will cooperate if such a person is requested.

5. In the case of suicide or other death invite the identified friends of the deceased to meet in a group at a selected site. This works better than suggesting that counselors are on hand to talk with any individuals who wish to discuss the death. Young people are more apt to take part in a group with peer support, at least initially, than they are individually. Note who does not take part since in some instances those persons most acutely affected do not attend a group meeting.

   These groups are best conducted with one or two adult leaders present. More than that may hamper the dynamics. On occasion, students will ask to meet by themselves, but such sessions tend to escalate the emotions and intensify the feelings and have not proved constructive.

In general, some activities are best avoided. Calling large assemblies to discuss suicide is not recommended, for instance. On the other hand, using such assemblies to communicate to students the readiness of school personnel to be supportive and to hear problems can be very worthwhile. Being told that one's school is a caring school, and that there are adults who will reach out, can be very reassuring.

6. Since each community mental health center has agreed to send additional personnel to schools outside its own catchment area if that appears to be necessary, please call Myra Herbert at the Department of Student Services and Special Eduction should such help be required.

   Know into which catchment area the school falls. The contact persons are:

   Ken Disselkoen, Northwest Center, 471-6030
   Betty Petercilia, Woodburn Center, 573-0523
   Lee Wick, Mount Vernon Center, 360-6910

7. Ask school staff to make themselves available to parents and other members of the community, if appropriate. When groups of parents have been invited to school to share feelings and be given some guidelines for communication at home, they have been very appreciative. When tragedies have occurred in elementary schools, letters sent home briefly explaining the situation and offering suggestions for further discussion, or anticipating the questions of the children, have proved worthwhile.

8. With regard to students being encouraged to do something in memoriam for someone deceased , be aware that there is a fine line between dramatizing a death and doing something appropriate that allows students to express a sense of loss and channel feelings. A small gesture can mitigate feelings of helplessness and communicate the concern of the school. Planting a tree, writing a poem, and donating blood to the Red Cross are examples of student gestures that have proved effective. It is recommended that any activity chosen be a one-time event, particularly when a student has been lost by suicide.

9. In instances where students wish to attend funeral services or actually take part in them by making a written contribution in some form, the wishes of the family must first be considered. Some families have welcomed such participation, but some have refused and requested that students not attend at all. It may then become necessary to work through the feelings about such wishes with the students.

10. In situations where suggestions made by students are inappropriate and refusal on the part of the administration causes anger among students, it is important to continue the dialogue. When issues are kept under discussion, the fervor tends to ebb and something mutually acceptable can be agreed upon.

FOLLOW-UP

1. Plan appropriate follow-up activities as needed for students and for faculties as well. Crises activate instabilities in children who may be at risk but who have remained unidentified. Offering ongoing support can often avert further tragedy.

2. Group meetings for bereaved students have often evolved from the initial sessions.

3. The mental health centers have sent professionals to the schools for designated periods of time to conduct individual sessions with students identified as troubled. Such sessions are voluntary and require parent permission.

4. Several elementary school librarians have compiled a useful list of reading material for young children on the subject of death. This has proved useful to teachers wishing to discuss death in their classrooms when the loss has been a classmate. That list is available from the Department of Student Services and Special Education.

5. Arrange crisis debriefing for those persons involved in the crisis management. These can take the form of one or two group sessions where both the crisis management and the personal stress are discussed. Myra Herbert from the Department of Student Services and Special Education and Ken Disselkoen from the Northwest Community Mental Health Center are available for assistance with this activity.

These guidelines represent the collaborative effort of a committee composed of persons who have been involved in school crises. All members are available for consultation.

Mary Ashton, Guidance Director, Oakton High School
Mike Chuey, Guidance Director, Robinson Secondary School
Elaine Creigh, Visiting Teacher, Area II
Jim Dick, Guidance Director McLean High School
Ken Disselkoen, Director, Prevention/Early Intervention Services, Northwest Center for Community Mental Health
Mitch Harrow, Psychologist, Area II
Myra Herbert, Coordinator of Social Work Services
Barrett Kashdan, Guidance Counselor, Chantilly High School
Betty McGowan, Visiting Teacher, Robinson Secondary Schools
Murriel Price, Superintendent, Area III
Joan Schnyer, Psychologist, Area III
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IV. THE STUDENT STRESS PROGRAM

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The student stress program is an activity designed to circumvent direct discussion of suicide with students but which focuses on many of the factors found to be prevalent in the populations at risk. Emphasis is placed on the social and emotional issues of adolescents.

The program was created in the central office and piloted in numerous high school where the response was very positive from students, parents, and staff.

The goal of the student stress program is to have a group of students make a panel presentation to other students, teachers, and parents dealing with the issues that are the most stressful for teenagers and using their personal experience as the basis for the discussion. The students are also encouraged to share their successful coping mechanisms.

The implementation of a student stress program requires the support of the principal, an active guidance counselor with good student relationships, and a staff member skilled in group processes who has experience with adolescent groups and is knowledgeable of adolescent issues. A mental health professional is suggested, perhaps a school social worker or psychologist with the appropriate skills.

Students selected to participate in the panel presentation should be those who have been functioning well, who are articulate, and who are willing to represent a particular point of view. Some of the causes of stress frequently mentioned by such students are:

- Academic pressure
- Social pressure
- Parental divorce
- Combined families
- Moving and having to readjust to a new school
- Learning disabilities
- Competition
- A family death
- Cultural differences
- Being in a minority

Students chosen to discuss stress are organized into a group. The group leaders, the counselor, and the mental health professional plan about six meetings over a six-week period. The meetings allow the group to coalesce as a group and the members to draw support from one another. The meetings also permit students to share and sort ideas because many of the students have multiple causes of stress to discuss. In addition, the process develops a focus on the issues in a particular school and that has greater meaning for the participants and for the eventual audience.

The group meetings are held in accordance with basic group techniqies:

- no more than two adults
- no interested observers
- regular attendance
- starting and stopping on time
- confidentiality (material sometimes arose that, while relevant, was not appropriate for a public meeting)
- discussion arising with minimum structure from group leaders.

When given a responsibility, in this case representation of a particular issue to a larger group of students perhaps dealing with the same issue and to parents, students rise to the occasion very well. They seem to gain confidence from the group's support and to be glad to have an audience. Far from being reticent, it has been our experience that adolescents speak out clearly when given the opportunity.

Six weeks also provides time to advertise the presentation on stress to the student body and the parent community through newsletters or the local newspaper, and it allows students time to "talk it up" throughout the student body.

The presentation is best introduced to the audience through a brief overview of adolescent issues—the classical, eternal ones and those that are the result of the changes in society. The student panel can then present its program in a number of different ways. Each student can do a five-minute statement, or each can introduce a subject and permit other panel members to make additions. Written speeches should be discouraged. Spontaneity is more rewarding for everyone. In some schools it has proved rewarding to have one evening meeting for the adults and another for the entire student body during a school day.

Questions-and-answer sessions are valuable but best monitored by one of the group leaders rather than the students. In our experience, it proved extremely useful to have a summary at the end of the program of the various resources available to teenagers and parents in the school and in the community. Having a community mental health representative or someone from an outside organization has proved effective. If possible, arrangements should be made to have student panel members available to other students the next day. Members of the school staff then have an opportunity to set up discussion groups for students about specific stress issues.

A final meeting is recommended for the student panel members to review the presentation. It is also useful to recognize that sensitive and personal material has been shared. Many students, both on the panel and in the audience, have a very positive human experience, one of the first steps away from despair for anyone.

Two television network productions have included coverage of these student groups in session.

In 1985 ABC Notebooks produced a half-hour program entitled TEEN SUICIDE. It is available from MIT Teleprograms, Inc., 108 Wilmot Road, Deerfield, Illinois, 60015.

In 1986 PBS filmed an hour-long documentary entitled GENERATION AT RISK which included sessions of the Student Stress Program.

CHECKLIST FOR WORKSHOP ON ADOLESCENT STRESS PANEL

- Elicit cooperation from the principal and ask for assignment of guidance counselor.
- Set date with counselor for evening panel leaving time for at least six group meetings. These should be at least once a week.
- Introduce the subject to the students. Give them a role, i.e., spokesman for a special interest group, community contributor, etc.
- Use non-directional group techniques. Do not program the student or tell them what to say. If you have not had some group work training, do not attempt to be the group leader. Organize the program and get someone else to lead.
- Lay some ground rules:
  — Two adults only
  — No interested spectators
  — Start and stop on time
- Begin by discussing issues in that school. Circumstances will differ according to the neighborhoods and the student body.
- Make certain the group interacts and use the dynamics. There will be a variety of viewpoints about almost every issue.
- Start the process of topic selection about the fifth meeting.
- Do not rehearse, just outline the issues.
- Don't let the participants write speeches. Cue cards are all right.
- Emphasize the time constraints. About five minutes per person works best.
- Sum up briefly at the end.
- Allow about ten minutes for questions and answers and monitor those. You may have to reinterpret some of them. Make sure the audience hears the questions.
- Arrange for some follow-up possibilities
  — Groups sometimes like to meet again to review the evening.
  — Participants' availability to other students is important.
- Tape, if possible, but don't forget the releases.

V. PEER COUNSELING

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The peer counseling elective in the high school curriculum of the Fairfax County Public Schools was not developed as a part of the adolescent suicide prevention program. A description of it is included here because it provides another forum in which issues related to suicide may arise, and it presents an opportunity for additional awareness and prevention activities. Members of the suicide prevention advisory committee constructed the suicide and crisis intervention sections of the curriculum. A copy is attached at the end of this section.

Peer counseling is an elective course designed to train and facilitate a peer counseling program in the school. The course presents information and training in the following areas of peer counseling preparation:

- Introduction, Purpose, Responsibilities and Logistics
- Verbal and Nonverbal Communication Skills
- Effective Communication Styles
- Self-Exploration and Self-Esteem
- Listening Skills
- Decision-Making/Problem-Solving
- Guidance Office Services and Education/Training Information
- Recognizing Crisis and At-Risk Situations
- Ethics, Confidentiality, Referral

Emphasis in the course is placed on experiential learning, supervised group activities and skill practice. The trainer presents concepts and theory (10 to 20 percent of class time), and students, with supervision, practice skills and critique peers' performance (80 to 90 percent of class time).

The peer counseling program provides the school staff an opportunity to help students develop interpersonal and support skills for assisting other students to grow socially, emotionally, and academically. The program takes advantage of the positive influence young people can have on one another for healthy change in behavior and attitude.

Peer counselors help other students learn to make successful decisions, to solve problems by exploring alternatives, and to discover their full potential as individuals. During the course students are encouraged to reflect feelings through open communication and honest feedback, to examine personal values and goals, and to develop sensitivity and awareness of others. Each peer counselor will work with an assigned student counselee in a one-to-one relationship. Peer counselors receive continuing supervision and are trained to immediately report any high-risk or life-threatening information to an adult supervisor.

Excerpt from:

Peer Counseling Curriculum, Fairfax County Public Schools

Unit VIII Recognizing Crisis and At-Risk Behaviors

Objective #8 To recognize serious clinical symptoms and times of crisis when counselees are at risk either to themselves or others.

To intervene in a constructive way and bring the matter to adult professional attention as rapidly as possible.

- Trainer presents and clarifies the students' understanding of crisis situations.

  a. Personal, internal crisis
  b. Situational crisis (family, friends, etc.)

- Trainers assist students to understand the combination of affect and situation that place counselees at risk.

  a. Suicidal behavior
  b. Aggressive behavior
  c. Child abuse
  d. Drug and alcohol abuse

- Trainers assist students to understand intervention and those situations which require immediate emergency action.

  a. Over-reacting
  b. Under-reacting

- Trainers assist students to be able to concisely articulate an emergency situation and remain calm.

- Trainers assist students to maintain objectivity.

  a. Over-identification
  b. Over-involvement

STATEMENT FOR THE UNITED STATES SENATE COMMITTEE ON THE JUDICIARY SUBCOMMITTEE ON JUVENILE JUSTICE

ADDRESSING THE ISSUE OF TEENAGE SUICIDE IN A PUBLIC SCHOOL SYSTEM

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October 3, 1984

Fairfax County, Virginia is a four-hundred-square-mile area outside of metropolitan Washington, D.C. It is largely affluent and middle-class with a median family income of $47,6000 and a per capita income of $14, 731 in 1983, but contains a variety of socio-economic and ethnic groups. In 1983, there was a minority population of 14.6 percent. Approximately 7 percent of that is black and the remainder Southeast Asian, Hispanic, and other smaller racial and cultural groups. In one high school, there are 60 different languages spoken.

The Fairfax County school system is the tenth largest in the United States. In 1984, there are 123,794 students enrolled in 162 schools. Forty-six of those schools are intermediate and high schools, some of which have populations of four and five thousand children. It is the population of these schools to which the suicide prevention program is aimed.

In the 1980-81 school year, there were 11 recorded adolescent deaths by suicide in Fairfax County. It must be understood that these were students enrolled who took their lives during the school year. There were a number of other deaths that occurred during vacations or immediately after graduation, or that were questionable enough to be recorded as accidental either because of the circumstances or because of the wishes of the family. The actual total was well over 20, perhaps higher.

In the 1982-83 school year, in response the Fairfax County School Board elected to make a suicide prevention program a priority and requested that the effort be organized to make it a cooperative school and community program. The Department of Student Services and Special Education, an umbrella department that encompasses a wide range of related services, rapidly organized a school/community advisory comittee with representation from the school system, the community mental health centers,the medical association, the mental health association and the police department. This committee served not only as an advisory committee, but took part in the implementation of the program, organizing speakers, and contributing expertise.

It was decided that the program should reach three groups: teachers, parents, and the students themselves. Every high school and intermediate school faculty was to have an inservice program that would address depression and suicide in children. Parent/teacher associations would be asked to organize correlated programs during the same period and all schools were asked to provide information and assistance to students. This was extended over a two-year period, 1982-83 for high schools and 1983-84 for intermediate schools.

It is not a small matter to organize a program within the confines of the school day. Schools are often criticized by outside agencies for not responding en masse to what may be viewed by some as a critcial need. If teachers were mandated to an assembly for a substantial period of time--often the suggestion--the classrooms would be unattended, and the needs of the curriculum would go unmet. Teachers must cover a specified amount of material in a specified number of hours and are held accountable for that coverage. There is the added aspect that in a county this large, all parents do not see all issues as equally important and can be vocal and critical of the school system for using time for other than academic subjects.

We therefore decided on a format that, while not ideal, could not provoke negative reaction. A regular 45-minute faculty meeting was designated as a workshop on adolescent suicide. This was designed to be a didactic session constructed to heighten the awareness of teachers and provide guidelines for talking with students and referring problems to the proper resources within and without the school. The following day, an all-day open house was to be held in a comfortable conference room where coffee was available. Teachers were invited to drop in during their free periods to talk with the school social worker, the school psychologist, a guidance counselor, often the speaker from the previous day, and community mental health professionals as they were available. These professionals stationed themselves in schools all day. This proved to be a very effective method of communicating. Many teachers asked questions they would have hesitated to ask in a larger more formal group, many brought in their own issues, and a great number referred children they had been worried about for some time but had not identified as having a specific problem.

Guidelines were developed for the material that should be covered by any speaker to any of the groups, the signs and symptoms of depression and suicidal ideation which children are apt to exhibit. It was stressed that a single factor is usually not significant, but clusters of factors are. (See Attachment A.) Every faculty member in the county was also given a Public Affairs Pamphlet that served as a ready reference. (See Attachment B.)

Community cooperation was excellent. Agencies and private practitioners gave generously of their time both to the schools and to the parent groups. The Division Superintendent gave the program full support and all schools held faculty programs. (See Attachment C.) At least three-quarters of the parent/teacher associations did the same. Student programs were not so widely successful. The administrators of many schools were cautious about doing something labelled "suicide" with students, many operating under the misguided notion that discussing the subject encourages the thought. Only one high school did a program that reached the entire student body. In working with students, however, one quickly realizes that they discuss the subject freely among themselves and have very little discomfort with it.

We therefore began to look at alternative methods of reaching students by a somewhat different route and reexamined those issues most mentioned as the causes of stress and unhappiness in adolescents. During 1983-84, we began to do organized programs on social and emotional issues with students. These took the form of doing in a particular high school about six hours of group work with functioning students known either by the guidance counselors or by friends to have "a problem" of some kind. Many had multiple issues but isolated one as the one to be addressed. These students then presented a panel for the entire student body, parents, and teachers at an evening session. They have offered their experiences with particular issues and their methods of coping. Needless to say, this has been both successful and rewarding. Adolescents are extremely self-absorbed and tend to think their situations are unique. This program too has been followed by an open house the following day, and students never identified as "troubled" have shown up to discuss problems they previously thought were theirs alone. They hear the experiences and listen to the advice of their peers much better than they hear adults.

We are expanding this effort during the 1984-85 school year and hope to reach every high school. We have made a videotape of one of these panels. It is about 30-minutes long and well worth the time it takes to view. Young people are open, honest, and spontaneous, and have proved very glad to have someone listening to them.

There is nothing more difficult to evaluate than a prevention program. There were, however, five deaths in the first year of the program and only three last year. This is again only the period during which school was in session. There were, however, also fewer deaths during holiday periods. Coincidence perhaps, but that is in inverse proportion to the national statistics. Mental health and guidance personnel in the schools report that the referral of students to their offices has risen significantly, and that faculties and administrators display an increased sophistication in identifying troubled situations. We have good reason to believe the program has had a positive impact and should be considered in other school districts over the nation.

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